STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX **File No. 100384-001**
Petitioner
v

United HealthCare Insurance Company
Respondent
_____/

Issued and entered
this 29th day of December 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 25, 2008, XXXXX (Petitioner) filed a request for external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner of Financial and Insurance Regulation accepted the request on October 2, 2008.

The Commissioner notified United HealthCare Insurance Company (United) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Regulation received the information from United on October 7, 2008.

The Petitioner, a student at XXXXX University (XXX), had health care coverage under a one-year nonrenewable student health care plan. The master insurance policy was issued to XXX. The Petitioner was given a brochure, United's "2007-2008 Student Injury and Sickness Insurance Plan" (the brochure) which defined her health care benefits.

The issue here can be decided by an analysis of the provisions of the brochure. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not

require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner received services at XXXXX (XXX) at XXXXX Hospital, a preferred provider, on seven dates from September 2007 through June 2008. United paid in part for care on May 23, 2008, and June 24, 2008, but denied all payment for any of the five earlier visits.

The Petitioner appealed the failure of United to pay for her care from XXX. United reviewed the claims but upheld its denial. The Petitioner exhausted United's internal grievance process and received a final adverse determination dated September 10, 2008.

III
ISSUE

Was United correct in denying coverage for the Petitioner's care from XXX?

IV
ANALYSIS

The Petitioner says that she was referred to XXX by physicians at XXXX Health Center at XXX because they thought XXX would provide better care to help her manage her type I diabetes and she would have her prescriptions filled in a timely manner.

United paid for part of her doctor office visits at XXX on May 23, 2008, and June 24, 2008, but denied payment for any part of the visits on September 21, 2007, October 9, 2007, November 2, 2007, November 15, 2007, and December 23, 2007. The Petitioner does not understand United's denial because the explanation of benefits form showed that claims filed under the same procedure code were both covered and denied. The Petitioner believes the services she received at XXXwere covered under her student health insurance.

The Petitioner also questions the way United applied the deductible to the services it did cover.

United indicates that the denied claims for the care the Petitioner received at XXX were

identified as facility charges. United says that the outpatient section of the "Schedule of Basic Medical Expense Benefits" (on page 9 of the brochure) provides benefits for physician visits, surgeon fees, anesthesiology, physiotherapy, diagnostic X-ray and laboratory services, etc. However, United says there is no benefit for a clinic charge or facility fee. Therefore, there were no benefits provided by the policy for facility fees.

However, United did cover doctor visits and the laboratory charges and says it applied the $45.00 "preferred allowance" for the laboratory services on December 4, 2007, to the $100.00 per sickness or injury deductible. United then satisfied the balance of the $100.00 deductible by applying $55.00 of the preferred allowance for the physician charge from the May 23, 2008 visit.

United believes that it has paid for the Petitioner's care at AIM in compliance with the terms of her plan and is not required to pay any additional amount.

Commissioner's Review

The claims denied by United as "facility charges" are shown in this table and include the procedure codes taken from the explanation of benefits forms:

Date of	Charge	Procedure
9/21/2007	$ 60.00	99201
9/21/2007	215.00	99204
10/9/2007	60.00	99211
10/9/2007	85.00	99213
11/2/2007	60.00	99211
11/2/2007	85.00	99213
11/15/2007	60.00	99211
11/15/2007	85.00	99213
12/4/2007	60.00	99211
12/4/2007	85.00	99213
5/23/2008	60.00	99211
6/24/2008	60.00	99211
Total	$ 975.00	

The Commissioner first notes that the Petitioner's insurance plan covers physician office

visits (see page 9 of the brochure, under "Outpatient" services). The question then is whether the services the Petitioner received on the dates shown in the table above were for physician office visits or were facility charges. The Commissioner looked at the procedure (or CPT) codes for the claims that were denied. Those CPT code definitions[1] are (in pertinent part):

> 99201 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires these three key components:
>
> - **A problem focused history;**
> - **A problem focused examination;**
> - **Straightforward medical decision making.**
>
> 99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires these three key components:
>
> - **A comprehensive history;**
> - **A comprehensive examination;**
> - **Medical decision making of moderate complexity**.
>
> 99211 **Office or other outpatient visit** for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
>
> 99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least two of these three key components:
>
> - **An expanded problem focused history;**
> - **An expanded problem focused examination;**
> - **Medical decision making of low complexity**. [Bold in original]

The Commissioner concludes, based on the CPT code definitions above, that all the denied claims were physician office visits, not facility charges. This is consistent with the Petitioner's description of the services. Moreover, as the Petitioner points out, United covered claims for

1 Source: *Current Procedural Terminology 2007*, Professional Edition.

procedure code 99213 at XXX as “doctor visit” on May 23, 2008, and June 24, 2008, according to the explanation of benefits forms, while denying that same code as a “facility charge” on other dates. The Commissioner finds that the denied claims in the table above were for physician office visits, which are covered under the Petitioner’s insurance plan, and shall be reprocessed as benefits according to the terms and conditions of that plan.

The Petitioner also raised questions about United’s processing of other claims for laboratory services on December 4, 2007, and physician visits on May 23 and June 24, 2008. The plan includes a $100.00 deductible for each injury or sickness and then a 20% copayment. The Commissioner has reviewed those claims and concludes that the deductible and copayment were correctly applied for those services under the terms of the Petitioner’s insurance plan.

V
ORDER

The Commissioner reverses United’s adverse determination of September 10, 2008. United shall reprocess the claims for services shown in the table above as covered physician office visits.

United shall cover the services according to the terms and conditions of the insurance plan within 60 days of the date of this Order and shall provide the Commissioner with proof of compliance within seven days of compliance. To enforce this Order, the Petitioner may report any complaint regarding coverage to the Office of Financial and Insurance Regulation, Health Plans Division, at its toll free telephone number, (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County.

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P. O. Box 30220, Lansing, MI 48909-7720.